

PERSONAL CARE SERVICES (PCS)
PHYSICIAN AUTHORIZATION FOR CERTIFICATION AND TREATMENT (PACT) FORM

Referral Date: _____ Date Initial Assessment Completed: _____ Date Last Reassessment Completed: _____

Provider Name: _____ PCS Provider #: _____ Provider Phone #: _____

Provider Address: _____

PATIENT INFORMATION

1. PATIENT FIRST & LAST NAME: _____

2. MEDICAID ID # (MID): _____ 3. SOCIAL SECURITY# _____

4. PATIENT ADDRESS: _____

5. PATIENT PHONE: _____ 6. SEX: ☐ Male ☐ Female 7. DATE OF BIRTH (mm/dd/yy): _____8. PATIENT LIVES: *Check all that apply* ☐ Alone ☐ w/Spouse ☐ w/Adult Child(ren) ☐ w/Parent(s) ☐ w/others

9. CONTACT PERSON'S NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ PHONE: (H) _____ (W) _____

10. ATTENDING PHYSICIAN'S NAME: _____ PHONE: _____

ADDRESS: _____

11. DATE OF MOST RECENT EXAM (mm/dd/yy): _____ 12. Vital Signs @ Assessment: B/P _____ T _____ P _____ R _____ Wt _____ Ht _____

13. REASON FOR REFERRAL: _____ Referral Source: _____

14. DIAGNOSIS (Specify date of onset and ICD-9 code): _____

15. CURRENT CARE (Type and Source): _____

ASSESSMENT

16. LIST ALL MEDICATIONS BELOW: (Name/Dose/Frequency/Route)

17. Self-Administered? ☐ Yes ☐ No If no, who assists? (Name/Relationship) _____ Reminders needed? ☐ Yes ☐ No18. Does the individual have any allergies?: ☐ No Known Allergies ☐ Yes If yes, LIST ALL KNOWN ALLERGIES BELOW:

PATIENT FIRST & LAST NAME:		MEDICAID ID#:	ASSESSMENT DATE:		
Limitations in Activities of Daily Living (ADLs)					
Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below. Check the applicable boxes. Indicate the days when assistance is needed in the blank beside a task. M=Mon T=Tues W=Wed Th=Thurs F=Fri S=Sat Sun=Sunday					
A. ADL Self-Performance Scores 0. INDEPENDENT: No help needed or oversight needed. 1. SUPERVISION: Oversight, encouragement, or cueing needed. 2. LIMITED ASSISTANCE: Individual highly involved in activity; receives hands-on help in <i>guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene self monitoring of meds and / or other non-weight bearing assistance.</i> 3. EXTENSIVE ASSISTANCE: While individual performs part of activity, substantial or consistent hands-on assistance <i>with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of meds and / or weight bearing assistance</i> is needed. 4. FULL DEPENDENCE: Full performance of activity by another.		A. ADL Self-Performance	B. ADL Support Provided	Place a check in the box if assistance is needed	
B. ADL Support Provided Scores 0. No set-up or physical help needed 1. Set-up help only 2. One person physical assist 3. Two+ persons assist and/or one person assist w/assistive equipment					
19.	Ambulation:	Note assistive equipment patient is to use while ambulating: <input type="checkbox"/> Cane <input type="checkbox"/> Quad cane <input type="checkbox"/> Walker <input type="checkbox"/> Bed/chair bound <input type="checkbox"/> other _____			
20.	Non-ambulatory/ Transfer:	Moving to and between surfaces: bed, chair, wheelchair, standing position. Note assistive equipment patient is to use during transfer: <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Electric wheelchair <input type="checkbox"/> Hoyer lift <input type="checkbox"/> Transfer Board <input type="checkbox"/> Trapeze Bar <input type="checkbox"/> other _____ Note self sufficiency once transferred _____			
21.	Nutrition:	<i>Check assistance needed with taking in food by any method.</i> <input type="checkbox"/> Oral <input type="checkbox"/> Parenteral <input type="checkbox"/> Tube _____ <input type="checkbox"/> Feed patient <input type="checkbox"/> Set-up only Dietary Restrictions _____ Supplements _____ Diet Ordered _____ Meal Prep: <input type="checkbox"/> 1 meal _____ <input type="checkbox"/> 2 meals _____ Kitchen cleanup (cleaning table, stove, washing dishes, putting away items used, sweeping) _____			
22.	Respiration:	<input type="checkbox"/> Normal <input type="checkbox"/> Dyspneic with minimal exertion <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Mechanical Oxygen: <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Nebulizer Treatments _____ A. Dust _____ B. Vacuum _____ C. Mop _____ D. Sweep _____			
23.	Endurance:	<input type="checkbox"/> Pt. is never short of breath (SOB) <input type="checkbox"/> Pt. is SOB when walking more than 20 feet or climbing stairs <input type="checkbox"/> Patient is SOB when walking less than 20 feet and or dressing self or using commode <input type="checkbox"/> Pt is SOB w/minimal exertion (i.e. eating, talking, performing ADLs, agitation) <input type="checkbox"/> Pt is SOB at rest <input type="checkbox"/> Pt has generalized weakness A. Change bed linens _____ B. Make bed _____ C. Grocery shop _____ D. Pick-up medicine _____ E. Pay utility bills _____ F. Take out garbage _____ <input type="checkbox"/> Check smoke alarm: _____			
24.	Skin:	<input type="checkbox"/> Normal <input type="checkbox"/> Dry, cracked or bleeding areas <input type="checkbox"/> Pressure areas <input type="checkbox"/> Decubiti A. Diabetic foot care required?: <input type="checkbox"/> Yes <input type="checkbox"/> No Freq: _____ B. Nail Care?: <input type="checkbox"/> Yes <input type="checkbox"/> No Freq: _____			
25.	Bathing:	A. Taking full body bath _____ B. Shower _____ C. Sponge bath _____ D. Shampooing hair _____ E. Clean bathroom after bathing _____ <input type="checkbox"/> Transferring in and out of tub and shower <i>Devices needed:</i> <input type="checkbox"/> Shower bench <input type="checkbox"/> Bath Safety Bars <input type="checkbox"/> Detachable shower head			
26.	Personal hygiene:	<input type="checkbox"/> Combing hair <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Cleaning dentures <input type="checkbox"/> Washing/drying face and hands and perineum A. Braiding or setting hair _____ B. Shaving _____			
27.	Dressing:	<input type="checkbox"/> Laying out clothes <input type="checkbox"/> Retrieving clothes from closet <input type="checkbox"/> Putting clothes on and taking clothes off <input type="checkbox"/> Donning/removing TED Hose <input type="checkbox"/> Donning/removing prosthesis A. ROM _____ B. Launder pt's clothes, bed linens, towels, and washcloths _____			
28.	Bladder :	<i>Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self.</i> <input type="checkbox"/> Normal <input type="checkbox"/> Ileostomy <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Condom Catheter <input type="checkbox"/> Occasional incontinence (less than daily) <input type="checkbox"/> Daily incontinence <input type="checkbox"/> Incontinence during the day and night <i>Devices/supplies needed:</i> <input type="checkbox"/> Bed/chair bound <input type="checkbox"/> Bedside commode <input type="checkbox"/> Elevated Toilet Seat <input type="checkbox"/> Bedpan <input type="checkbox"/> Urinal <input type="checkbox"/> Pads <input type="checkbox"/> Diapers <input type="checkbox"/> Cath Care			
29.	Bowel:	<i>Rate assistance needed & frequency of assistance needed for cleaning, changing or transferring self.</i> <input type="checkbox"/> Normal <input type="checkbox"/> Occasional Incontinence (less than daily) <input type="checkbox"/> Daily incontinence <input type="checkbox"/> Constipation <input type="checkbox"/> Ostomy <i>Devices/supplies needed:</i> <input type="checkbox"/> Bedside Commode <input type="checkbox"/> Elevated Toilet Seat <input type="checkbox"/> Bedpan <input type="checkbox"/> Pads <input type="checkbox"/> Diapers <input type="checkbox"/> Enemas _____ <input type="checkbox"/> Bowel Program _____			
30.	Self-monitoring:	Self-monitoring of: <input type="checkbox"/> Pre-poured medications <input type="checkbox"/> Blood Sugars: Notify MD if BS is above _____ or below _____ BP: Notify MD if BP is > _____ or < _____ <input type="checkbox"/> Weight: Notify MD if pt. loses or gains ____lbs. within ____days.			

PATIENT FIRST & LAST NAME:		MEDICAID ID#:	ASSESSMENT DATE:
Other Client Information			
Check the appropriate box if it applies to the patient.			
31.	Pain: <i>7-day look-back</i>	Location of pain _____ Severity of Pain: <i>Rate 0 – 10: 0=no pain and 10=worst pain</i> _____ Pain frequency: <input type="checkbox"/> No pain <input type="checkbox"/> Pain < daily <input type="checkbox"/> Pain > daily Pain control: <input type="checkbox"/> No pain <input type="checkbox"/> Pain improved with medication <input type="checkbox"/> No pain relief or improvement w/medication	
32.	Cognitive Skills for Daily Decision Mkg:	<input type="checkbox"/> Independent (decisions consistent/reasonable) <input type="checkbox"/> Modified independence (some difficulty in new situations only) <input type="checkbox"/> Moderately impaired (decisions poor, cues/supervision required) <input type="checkbox"/> Severely impaired (never/rarely makes decision) <input type="checkbox"/> Patient requires step-by-step verbal prompting <input type="checkbox"/> MR/DD _____ (level)	
33.	Behavior:	<input type="checkbox"/> Cooperative <input type="checkbox"/> Passive <input type="checkbox"/> Physically abusive <input type="checkbox"/> Verbally abusive <input type="checkbox"/> Wanders <input type="checkbox"/> Injures self/others/property <input type="checkbox"/> Non-responsive	
34.	Vision:	<input type="checkbox"/> Adequate for daily activities <input type="checkbox"/> Limited (sees large objects) <input type="checkbox"/> Very limited (blind) <i>Client uses:</i> <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	
35.	Hearing:	<input type="checkbox"/> Adequate for daily activities <input type="checkbox"/> Hears loud sounds/voices <input type="checkbox"/> Very limited (deaf) <i>Client uses:</i> <input type="checkbox"/> Hearing aids	
36.	Speech:	<input type="checkbox"/> Normal <input type="checkbox"/> Slurred <input type="checkbox"/> Weak <input type="checkbox"/> Other impediment: specify _____ Primary Language(s) Spoken _____	
37.	Communication Method:	<input type="checkbox"/> Speech <input type="checkbox"/> Gestures <input type="checkbox"/> Writing <input type="checkbox"/> Assistive Device: specify type _____ <input type="checkbox"/> Client unable to write; have client make mark here: _____ Nurse's initials: _____	
38. <input type="checkbox"/> Additional time needed. Document here information specific to client needs for other covered home management tasks AND exceptions requiring additional time over identified time guidance:			
39. Patient's perception of what he/she thinks their needs are:			
40. Please check if any of the following apply to this patient: <input type="checkbox"/> Presence of continuous and/or substantial pain interfering with individual's activity or movement <input type="checkbox"/> Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen <input type="checkbox"/> Due to cognitive functioning, individual requires extensive assistance in routine situations. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time. <input type="checkbox"/> Bowel incontinence more often than once daily <input type="checkbox"/> Urinary incontinence during the day and night			
41. Has the patient executed an advance directive (living will or durable power of attorney)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify location of original doc.: _____			
42. Is there a DNR order? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, was DNR order discussed with pt.? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a copy of the DNR been obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, has the MD been contacted to obtain copy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
43. SAFETY ASSESSMENT: Is the patient's home adequate or suitable to carry out the Plan of Care according to your agency's policies? <input type="checkbox"/> Yes <input type="checkbox"/> No Water: _____ Telephone: _____ Heating: _____ Cooling: _____ Electric Capability Sufficient? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a smoke alarm in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a fire extinguisher in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If O ₂ is in use, have safety precautions been included on Plan of Care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Are there safety devices located in the bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No Are patient emergency numbers in clear view? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient confined to bed or chair? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient been instructed on the use of Durable Medical Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No List the DME company used : _____ Specify what DME is already available: _____ Specify what DME has been ordered: _____			
44. Are there sources (family, friends, programs, or agencies) available to meet the above needs at the time that services have been requested? <input type="checkbox"/> Yes <input type="checkbox"/> No			

NURSE ASSESSOR CERTIFICATION

I certify that I, and no one else, have completed the above in-home assessment of the patient's condition. Falsification: an individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and will be referred to the NC Board of Nursing for investigation.

☐ Based on the assessment, I have determined that the patient needs Personal Care Services due to the patient's medical condition. I have developed the plan of care to meet those needs.

☐ I have determined that the patient does not meet the criteria for personal care services.

PRINT RN NAME

RN SIGNATURE

Date Signed: Time in /out of home

PATIENT FIRST & LAST NAME:	MEDICAID ID#:	ASSESSMENT DATE:
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PLAN OF CARE

45. If the assessment indicates that the patient has medically-related personal care needs requiring Personal Care Services, show the plan for providing care beside the day(s) services are needed. Please write in the category # of the assigned task(s) that is designated on the assessment. The key below lists the category numbers. Be sure to write in the time (in 15 minute increments or in hours) required for each day.

Category #	Category Name	Category #	Category Name
19	Ambulation	27	Dressing
20	Non-ambulatory/Transfer	28	Bladder
21	Nutrition	29	Bowel
22, 23	Respiration	30	Self-monitoring
23	Endurance	30	Medication Assistance
24	Skin	31	Pain
25	Bathing	32	Cognitive Skills for Daily Decision-making
26	Personal hygiene	33	Behavior

Day of the Week	Task(s) To Be Accomplished Specify the category # and the amount of time required for each task (i.e. # 19: 15 minutes)	Total Time per Day (in 15 min increments or in hours)
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

46. **Goals/Objectives:** The need for PCS is expected to ☐change OR ☐end on ____/____/____. If no change is expected, state why:

47. Has a **verbal order** been obtained to **assess the patient** and determine eligibility for PCS per DMA Guidelines? ☐Yes Date: _____

48. Specify the date that a verbal order was obtained to **start PCS**: _____ Who conveyed/obtained this verbal order? _____

PHYSICIAN CERTIFICATION

I certify that I am the patient's primary physician and the patient is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the Personal Care Services in the above plan of care. Falsification: an individual who certifies a false statement in this plan may be subject to investigation for Medicaid fraud and will be referred to the North Carolina Board of Medicine.

ATTENDING PHYSICIAN'S SIGNATURE _____ DATE _____